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J. O.

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A HOPEFUL SIGN

In these hectic days when the economic philosophy of the government is such that it is viewed with alarm by numerous substantial men, it is refreshing to note that, in the 16th Congressional District of Texas, all three aspirants for the Congressional seat are unalterably opposed to socialized medicine. When the government sets its course in such a manner that it attempts to defend deficit spending, it becomes the duty of all public spirited individuals to exercise their franchise. When a government by its actions indicates it believes that a deficit is actually an excellent policy because it makes for more purchasing power, and this in turn makes for more business, one must pause and reflect seriously on this rather socialistic economic philosophy.

In order that socialism gain a foothold it must have roots, and these roots by all indications are manifested by the attempt to control the physician, and in turn the health of the nation. The Honorable Ken Regan, Congressman from the 16th Congressional District of Texas has been and still is unalterably opposed to socialized medicine in any form. His views as regards socialized medicine have been heard in Congress, and SOUTHWESTERN MEDICINE in a recent issue has published his views in full. In the coming Democratic primary, Mr. Regan is opposed by two candidates, Mr. Fred Hervey, and Judge Paul Moss. In order that fair play be maintained, the Editorial Board of SOUTHWESTERN MEDICINE believes that its readers should know the views of all concerned, and considers it a privilege to publish the following statements:

Fred Hervey Candidate for Congress from the 16th District of Texas, says:

"I am unalterably opposed to socialism in all its forms. Therefore, I am unalterably opposed to socialized medicine. I believe the American people are now solving the problem of medical costs. Nationwide group hospital-medical insurance grows by leaps and bounds. Costs to the individual decrease. Benefits increase sharply. This is the American, the Texan way. I believe our people, allowed to work things out their own way, are capable of solving any problem concerning their own welfare without reference to foreign political doctrines."

Judge Paul Moss in a letter to your editor makes his position very plain. He states:

"I have made every county seat in the nineteen counties in the 16th Congressional District, and find practically no sentiment in favor of socialized medicine. West Texas will be the last place to advocate socialized medicine. As stated in my opening campaign speech, April 8, I am not in favor of socialized medicine, and I will oppose any form of legislation for compulsory health insurance."

It is apparent that West Texas opposes socialized medicine, or any other form of socialism, and it is safe to say that its neighbors, Arizona and New Mexico, undoubtedly have the same views. It might be well, however, for the medical profession in the aforementioned states to solicit the views of their candidates for Congress; because, in the final analysis, it is the medical profession, not the politicians, who must insure the health of the community.

Disaster and Welfare Agency

Gen. George C. Marshall, recently appointed President of the American Red Cross, "now turns his wisdom, experience and great heart to guide the official humanitarian arm of the military forces and the nation's foremost disaster and welfare agency." — New York Herald Tribune.

Community Rheumatic Fever Programs

Undoubtedly, the best approach for the control of rheumatic fever and rheumatic heart disease is a community program such as that advocated by Rutstein* in a pamphlet released by the American Heart Association in January, 1950. The following benefits to the community are stressed:

1) Prevention of Acute Attacks of Rheumatic Fever — Treatment of streptococcal infections with penicillin will prevent subsequent attacks of rheumatic fever if the prophylactic treatment with penicillin is begun promptly after onset of the streptococcal infection.

2) Precise Diagnosis — Because rheumatic fever is a difficult disease to diagnose, even for the expert, and because there is harm if it is either over-diagnosed or under-diagnosed, a consultation service by physicians specially trained in rheumatic disease would be of great value to both the patient and his private doctor.

3) Proper care of Patients, in All Stages of Rheumatic Fever — A survey of community facilities, leading to coordination of effort and better organization, would promote the best use of facilities to give the most satisfactory handling for individual cases. Such patient care should include case finding and registration, as well as hospitalization and provision for home nursing as indicated.

4) Prophylaxis of Recurrent Attacks—This phase of the program, in addition to the prophylactic use of sulfonamides, penicillin or aureomycin, could stress the advantage to the individual patient of isolation from possible contact with streptococcal infections. Such protection might be at the home level or in an institution.

5) Prevention of Subacute Bacterial Endocarditis — Special arrangements could be provided for any rheumatic fever patient requiring operative intervention, especially for extraction of teeth, tonsillectomy, operations on lower gastrointestinal tract, or for a pregnant woman at time of delivery. The proper isolation and drug therapy could be arranged to protect against invasion with hemolytic streptococci or Streptococcus viridans.

6) Vocational Training and Education — It is difficult for the individual patient in a home to have the right guidance for either vocational help or schooling, but such can be readily handled within a community rheumatic heart program.

CONCLUSION

Rheumatic fever with subsequent rheumatic heart disease has been the most serious disease hazard for the school-age child. The newer approaches to therapy which take into consideration our modern concepts of etiology, together with wise planning for prophylaxis in a carefully organized community health program, should markedly reduce the dangers from this disease. The newer therapeutic agents give promise of soon aiding us to prevent this disease in a high percentage of potential cases.

* Rutstein, D. D.: Heart Disease Programs—Clinical Basis and Organizational Aspects. American Heart Association, 1775 Broadway, New York 19, N. Y., 1950.

Free Rides

The American Red Cross Motor Service clocked up more than 9,000,000 miles last year on assignments for hospitalized servicemen, veterans' military personnel, and civilians, including crippled children and adults, transporting disaster workers and supplies, assisting in the Red Cross blood program and in other Red Cross work.

De Rebus Medicis Et Politicis

BY ROBERT B. HOMAN, JR., M. D., EL PASO, TEXAS
MEMBER OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

REORGANIZATION PLAN NO. 27

David Hinshaw* has written the following choice morsel for American digestion:

"The presidency, first of all, has become an evangelist's pulpit. Over the decades and the generations the presidency has grown into the nation's headquarters for making public sentiment, and after making it to channel it through Congress. Thus the president's job, rightly or wrongly, has become that of leading the American people — all one hundred and fifty million of us, rich or poor, intelligent or dumb, kindly or vicious."

This, of course, means that the executive branch of the Republic has become the sales department. With the help of "advisors", "brain trusters", and bureaucrats, the President, as sales manager, attempts to sell a bill of goods to the American people, chiefly designed to keep the manager and the bureaucrats, et al., employed by the tax-payer.

"FIRESIDE CHATS"

Franklin Roosevelt's "fireside chats" were the epitome of this technique. His "trial balloon" methods through the newspaper columns of Eleanor Roosevelt and other New Deal columnists were a close second. Mr. Truman's advisors know that his type of political address would never do for radio consumption as a "fireside chat". Thus they put him on the road, at the tax-payer's expense, of course, to "tell the truth to the American people". Both techniques have one thing in common. They ask for the purge of the Congressmen, elected by the people, who have the audacity not to believe everything the sales manager says.

In the summer of 1947, Congress approved the Lodge-Brown Act, which authorized the formation of a non-partisan commission, now known as the Hoover Commission, to reorganize our bunglesome and extravagant government. About twenty-five per cent of the recommendations of this great commission have now been adopted by the Congress. If all of them were to be accepted, many billions of dollars would be saved annually, many bureaucrats would be looking for jobs; and Americans would be better served by their elected and appointed officials.

CITIZENS' COMMITTEE

A Citizens' Committee for the Reorganization of the Government Executive Branch was organized shortly after the Hoover Commission reported. This committee, composed of men and women in all walks of life, went to work on the adoption of the commission's report — realizing that only the voice of the people could bring about the vast and important changes recommended. As a result, reorganization of the government became a national and popular issue. A further result was that the administration's advisors saw an opportunity to do a little re-organizing of their own — ostensibly acting on the report of the Hoover Commission.

Reorganization Plan No. 1 was one such distortion of the Hoover Report. It was a coarse attempt to place Mr. Oscar Ewing, the frontman for socialized medicine, in a cabinet post with authority over a "Welfare Department", to embrace medicine, education, and social security. It was not the recommendation of the commission. It was vetoed by the Senate by a vote of 60 to 32, largely through the opposition of the medical profession. Immediately the administration press attacked the doctors as obstructionists to reorganization and to the Hoover Commission report! This was just another attempt of the present administration to discredit the profession — a habit well formed!

MANY AGENCIES

The Commission had found that there are **forty-eight** government agencies spending money for health and medical services! They found no rhyme or reason to hospital construction, maintenance, and occupancy among Army, Navy, Public Health, or Veteran's hospitals. They found federal hospital construction costs ran from $20,000 to $51,000 per bed while private construction cost averaged $16,000 per bed. They found 40% to 50% occupancy of government beds in certain urban areas, with other federal agencies prepared to add more thousands of beds in the same area. The waste, not only of money, but of medical, nursing, and administrative personnel is appalling.

For these reasons, and others, the Hoover Commission recommended a United Medical Administration; which, among other things, would administer all of our federal hospitals in this country. This administration should be under the director of an administrator, who would see to it that existing facilities, both public and private, are used and who would also have responsibility for developing plans for new hospitals on something other than a hit-or-miss basis.

PROCEDURE

Under the act, the President may submit reorganization plans to Congress effecting any department of the Executive Branch. Unless a plan is vetoed by resolution in either the Senate or the House, within 60 days after submission, the plan becomes effective.

On May 31, 1950, Mr. Truman submitted Reorganization Plan No. 27 to the Congress. It is almost identical with the defeated Reorganization Plan No. 1. Plan No. 27 would create a "Department of Health, Education, and Security", headed by a Secretary of Cabinet rank. The sales manager has simply dropped the "Welfare Department" but he still has his eye on Mr. Ewing as a cabinet Officer.

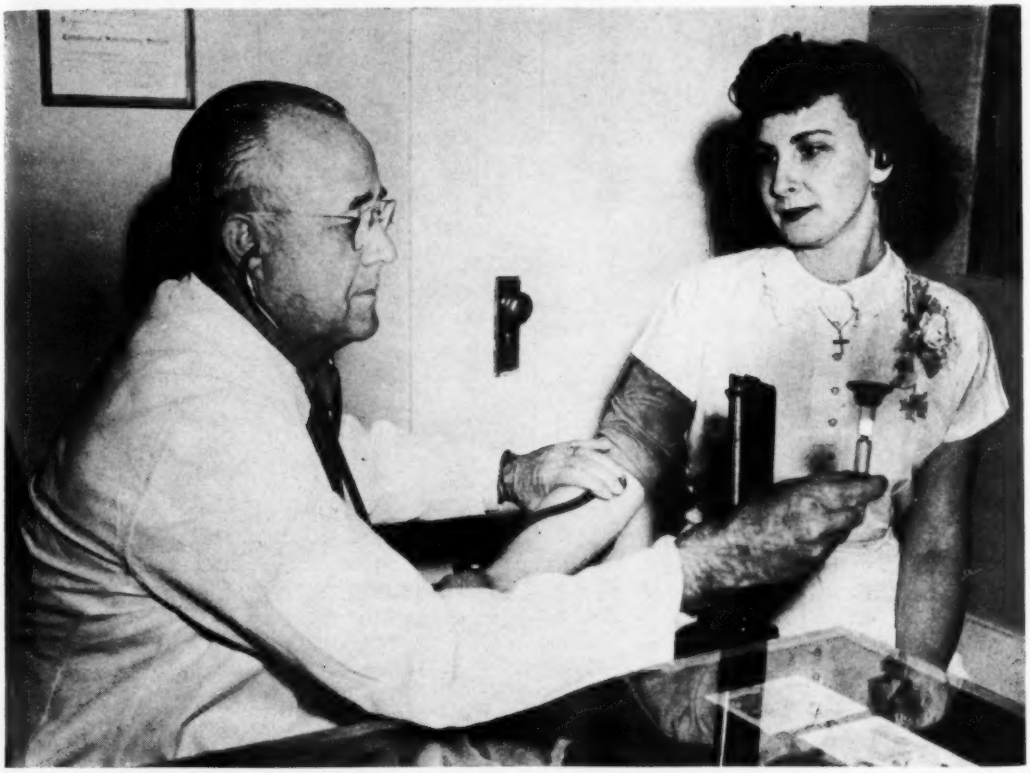
NO MENTION

In this latest plan there is no mention of the "United Medical Administration" recommended by the Hoover Commission. This was to be a single independent agency to administer medical problems. For this reason the Citizen's Committee for the

(Continued on Page 230)

* Author of the new book, "Herbert Hoover, American Quaker". Farrar-Straus & Co.

EGG TIMER MEDICINE



Dr. Ralph H. Homan, president of El Paso County Medical Society, administers the three-minute egg-timer treatment to a pretty patient who is being cured of all thoughts of socialized medicine.

Jerry Harris, Manager of the Creditors Service Bureau of El Paso, is well known to the medical profession of the Southwest. Mr. Harris is a businessman, and a devout advocate of free enterprise. Recently he has in a very unique manner expressed his distaste for state-controlled medicine. He is presenting to each interested practitioner of medicine a simple egg timer which he may place in a conspicuous place in his office. He has also placed in the hands of physicians copies of the following memorandum to be presented to patients:

THIS IS AN EGG-TIMER.

It takes three minutes for the sand to flow from the top to the bottom. Hardly time enough to turn around, is it?

And yet, in England, under socialized-medicine, *three minutes is the average time most doctors can give each office patient!*

Three minutes may be long enough to boil an egg, but having only three minutes to consult with a doctor, receive his diagnosis and have him prescribe, is not what *YOU* want for yourself and family, is it?

Look at it this way. When you hear them say "free" medicine, you ought to understand they're only kidding. *Someone* has to pay for it. Know who that will be? Yes, you've guessed it—*YOU!*

And in more than one way, too. Not just in additional taxes, for you'd have to expect those immediately. In addition, you'd be sacrificing your right as a citizen to select the physician of your choice.

You'd be losing the benefit of the research that has placed America in the forefront of medical discovery and in tremendous advances in conquering dread diseases.

Under our free enterprise system, we lead the world in more hospital beds per capita population, in a vastly lower death rate and a greater life expectancy.

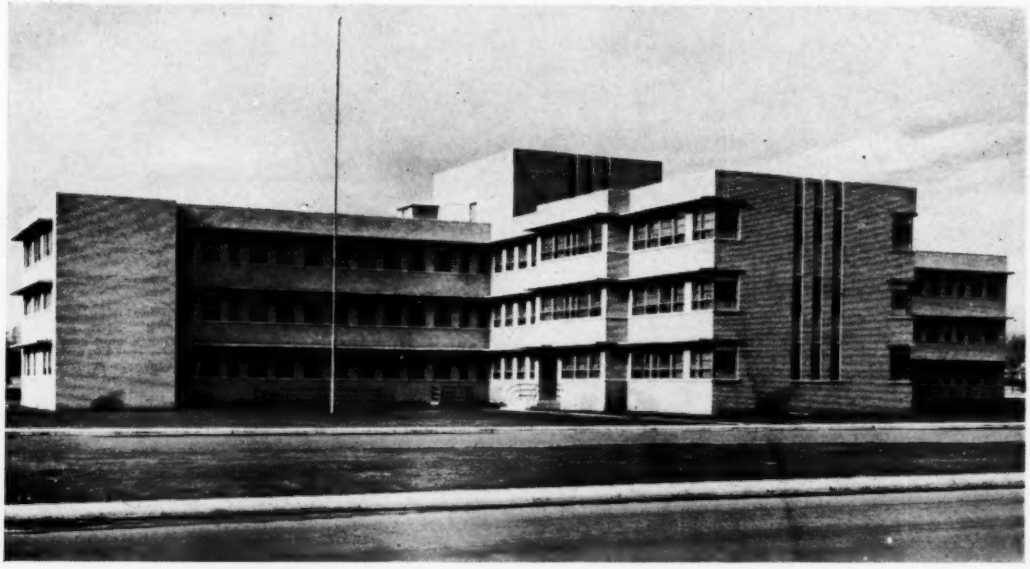
Were we to accept the stumbling, fumbling British system in place of this, what would happen?

EGG-TIMER MEDICINE!

Is that what *YOU* want? We think NOT.

SOUTHWESTERN MEDICINE takes this opportunity of thanking Mr. Harris for his interest in the preservation of good medicine, and sincerely hopes that its readers will avail themselves of his offer. It is dramatic. When the patient watches the sand flow, and begins to realize that in three minutes his visit with his physician is finished, he then at least has doubts as to the ability of his physician's rendering him the type of service which he desires.

NEW ECTOR COUNTY HOSPITAL



This handsome new Hospital located in Odessa, Texas, one of the Southwest's fastest growing cities, was built by Ector County officials without the aid of either private or federal contributions.

SOUTHWESTERN MEDICINE wishes to extend its heartiest congratulations to the citizens of Ector County on the occasion of the activation of the Ector County Hospital. This is indeed a unique project; for this hospital was built and paid for by Ector County without federal financial aid, and without voluntary donations. The physical plant is most modern, and was built at a cost of one million dollars. Its equipment leaves nothing to be desired and furnishes adequate facilities for expert medical care.

The County Commissioners may well be proud of their part in the realization of this fine institution, because to realize such an undertaking entails considerable work. The members of the commission are: H. R. Bethel, Tine Davis, W. W. Orchard, and O. E. Gerron. Judge Stoker heads the commissioners court. Other officials who work closely with the court are County Auditor J. C. Hamilton and County Treasurer S. R. McKinney.

The management of the hospital is directed by a lay board of hospital managers. Chairman Hardwick, Vice Chairman Charles B. Perry, Secretary W. Mapp and members Gene Cody, Paul Salter, and H. L. Cooper, with Judge Stoker serving as an Ex Officio Member, constitute the Board of Managers.

The administration of the hospital is directed by C. C. Gibson. Mr. Gibson with his trained and efficient personnel has been able to give the citizens of Ector County an institution of which they can be justly proud.

The medical staff is headed by Dr. J. K. Wood with Dr. O. A. Fulcher serving as vice president, and Drs. Thomas B. Abney, Gordon V. Lillie and Ranier as executive members. Twenty-two doctors are on the staff. The city of Odessa is one of the most progressive and most rapidly growing communities in the Southwest, and its civic pride cannot help from being enhanced by this institution. The doctors of Odessa are to be congratulated, as this represents a forward step in the practice of good medicine under the system of free enterprise. If we are to maintain the high standards of the profession, we must all go forward and not be satisfied with anything except the most modern and best.

The citizens of Ector County have amply demonstrated that they had faith in the medical profession, and have no wish to have the Federal Government enter into the practice of medicine. This is as it should be, and constitutes a hopeful sign in the right direction.

Contraindications to Dicumarol Therapy

The contraindications for using dicumarol must always be clearly recognized. They may be summarized:

1. In renal disease the effect of dicumarol may be abnormally prolonged and difficult to control and therefore should not be used.

2. In ulcerative lesions and open wounds including ulcerative colitis, and also in patients undergoing tube drainage of viscera.

3. In patients with recent operations on the brain or spinal cord hemorrhage might be disastrous.

4. In deficiency of vitamins C or K; in liver disease with prothrombin deficiency; and in blood dyscrasias or purpura.

5. In subacute bacterial endocarditis because the hemorrhagic tendency is increased.

6. In patients with hypertension having retinopathy.

"Thrombophlebitis" — Fay Le Fevre, M. D., Department of Cardiorespiratory Disease, Cleveland Clinic Quarterly, January, 1950.

SOME CURRENT PROBLEMS IN DIAGNOSIS AND MANAGEMENT OF PNEUMONIA*

By Elias Strauss, M. D., Dallas, Texas**

The falling death rate from pneumococcal pneumonia and the equally remarkable decline in the incidence of this disease attest the efficacy of modern chemotherapeutic and antibotic agents. Nevertheless, the use of these drugs does not exempt the practitioner from his responsibility for accurate diagnosis, nor does it always solve the problems of management of pneumonia. Indeed there are not uncommon instances in which the use of potent therapeutics adds to the difficulties and complexities of diagnosis and management.

Intelligent treatment is based upon etiologic diagnosis. In hospital practice, pre-treatment blood culture and culture of the sputum should be obtained, although it is not necessary to await the results of these tests before therapy is undertaken. At the present time, blood cultures yield information of value in prognosis only in exceptional circumstances; and hence, they may generally be omitted, when difficult to obtain, without prejudice to the patient's welfare. However, the value of properly performed sputum examinations cannot be overstated. The sputum should be streaked on the surface of a blood agar plate; and, after suitable incubation, the predominant flora identified.

This practice enables one to recognize the unusual cases of staphylococcus and Friedlander bacillus pneumonia, which cannot be expected to respond to treatment with penicillin. There are few patients who produce no sputum, when the effort is made to obtain it; and there are few laboratories so ill-equipped that cultures cannot be made. When circumstances do not permit cultural studies, the practitioner may still obtain information of value in the diagnosis and management of pneumonia, if he himself will examine a simple gram-stained smear of sputum to determine whether the bacterial flora is pre-dominately gram-positive or gram-negative.

It should not be forgotten that the bacterial flora may change during the course of pneumonia and as a result of treatment. This point is illustrated in the first case to be presented.

REPORT OF CASES

CASE 1

An 18-year-old colored boy was admitted to Parkland Hospital on October 7, 1949. For three days he had been feverish, weak and dizzy with pain in the right side of the abdomen. Later, the pain involved the chest and was aggravated by breathing and coughing, and he began to raise blood-streaked sputum. When admitted he appeared acutely ill, dyspneic, splinting the right side of the chest, and had a temperature of 102.6, pulse rate of 100, and respiratory rate of 30 per minute. Signs of lobar consolidation and pleural friction rub were elicited over the middle of the right side of the chest. The blood culture yielded

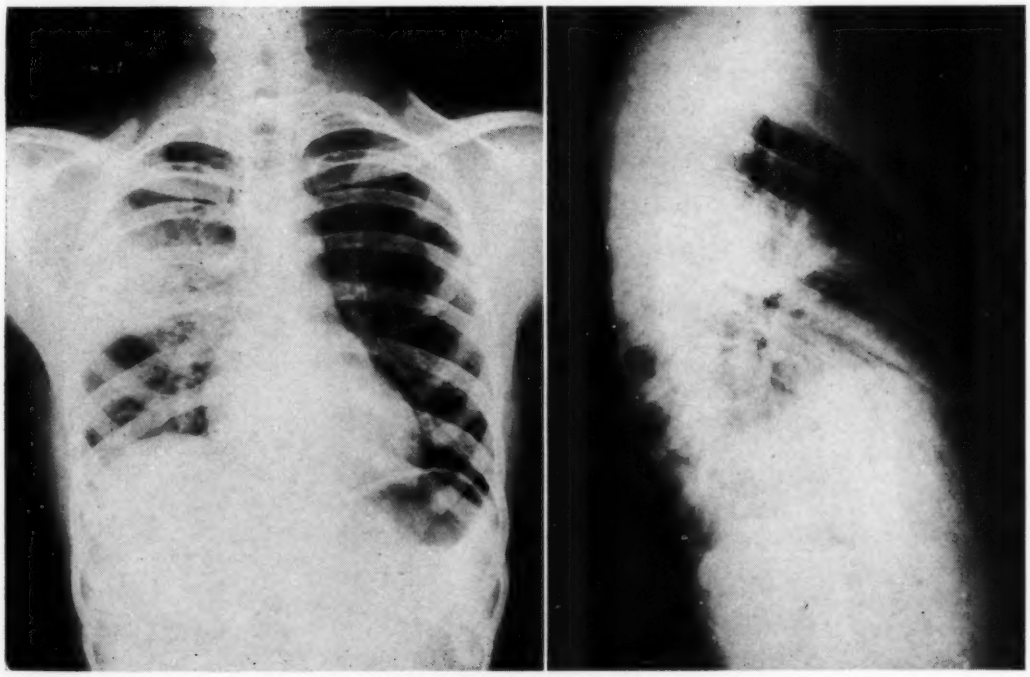


Figure 1. Case 1. Postero-anterior and lateral views of chest on admission to the hospital. Note lobar consolidation involving lower portion of right upper lobe.

* Read before the Texas Academy of Internal Medicine, Dallas, Dec. 10, 1949.

** From the Department of Preventive Medicine and Public Health, Southwestern Medical College, Dallas, Texas.

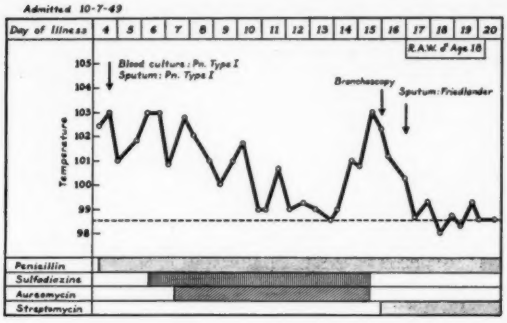


Figure 2. Case 1. Lobar pneumonia due to pneumococcus type 1 with slow or doubtful response to penicillin, sulfadiazine and aureomycin. Recurrence of fever and spread of pneumonia associated with finding of Friedlander bacilli in sputum. Response to streptomycin.

pneumococcus, Type 1, and the sputum culture also revealed pneumococcus, Type 1, as the predominant bacterial organism. The leukocyte count was 12,000 cu.mm. with 88% polymorphonuclear leukocytes. The results of urinalysis were not unusual. X-ray examination of the chest revealed lobar consolidation involving the lower portion of the right upper lobe (Figure 1). The course of illness, and the treatment given are depicted graphically in Figure 2.

Penicillin was injected intramuscularly, 100,000 units every 6 hours. However, after 48 hours of this treatment the patient still appeared acutely ill, the temperature was 103 degrees, and physical signs and x-ray studies indicated a spread of the disease to the right middle and lower lobes. Accordingly, sulfadiazine was administered by mouth, beginning with an initial dose of 4 grams and then one gram every 4 hours. He continued to receive penicillin also. Despite this combined therapy, and with blood concentrations of 12 to 14 mgs per cent of sulfadiazine, no clinical improvement was observed.

At this point aureomycin was administered, 4 grams a day in divided doses, while both penicillin and sulfadiazine were continued. The temperature then gradually declined and reached normal on the 7th hospital day.

Fever recurred several days later and on the 11th hospital day, the temperature rose to 103 degrees. Decision was required as to whether this represented drug fever or a complication of the infection. Treatment with aureomycin and sulfadiazine was discontinued. Because of the possibility of atelectasis, bronchoscopy was performed with aspiration of inspissated secretions from the middle and right lower lobe bronchi. At this time it was observed that the sputum, which at the time of admission was thin and blood streaked, had now become purulent, copious and very tenacious. Gram-stains of the sputum revealed a predominance of gram-negative coccobacilli.

Cultures subsequently showed that the pneumococci had disappeared, and that the chief organisms present were Friedlander bacilli (Klebsiella). Ac-

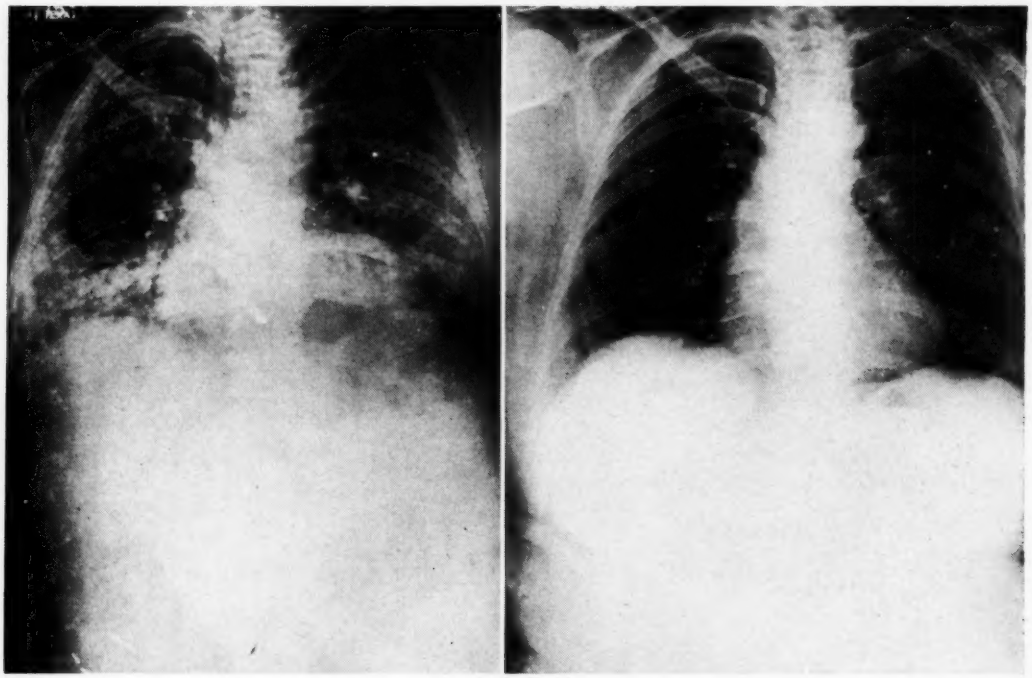


Figure 3. Case 2. Left: November 15, 1948. Diffuse bilateral broncho-pneumonia due to leptospirosis (Weil's disease).

Right: Dec. 23, 1948. Complete recovery; clear lung fields.

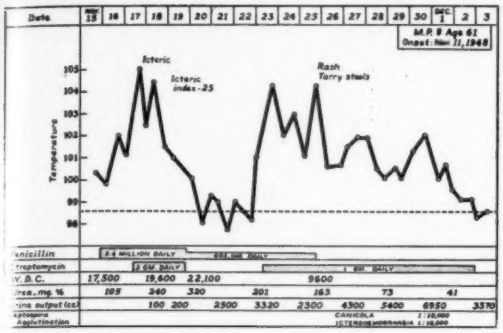


Figure 4. Case 2. Weil's disease. Note time of appearance of jaundice and of bleeding tendency in relation to onset. Azotemia and oliguria prominent features. Diagnosis established by serological tests.

cordingly, the patient was now treated with streptomycin, with slow resolution of the pneumonia and gradual decrease in the amount of sputum.

COMMENT

This case was instructive in several respects. It is apparent from inspection of the temperature chart that the disease was not obviously influenced by penicillin. Likewise, it would be difficult to prove that either sulfadiazine or aureomycin were responsible for the favorable outcome. In fact the temperature returned to normal by lysis at about the anticipated time, even if no specific treatment had been given. Although it is sometimes difficult to explain, the fact is recognized that some patients with proved pneumococcal infections respond slowly and incompletely to treatment with penicillin. The usual clinical rule-of-thumb that pneumonia which does not respond favorably to penicillin within 48 hours is "virus" pneumonia is by no means a safe guide for diagnosis or treatment.

This case also illustrated the problem of differentiation between drug fever and a complication of the disease itself. This is a problem which increases in difficulty as polyvalent antibiotic therapy becomes more popular. In this instance three drugs were being administered, any one of which could have been responsible for the recurrence of fever.

Finally, the case demonstrated a phenomenon which is becoming more prevalent since the use of potent chemotherapeutics, namely, the replacement of one species of bacteria by another, resulting in perpetuation or recrudescence of the disease. Penicillin is so potent a bactericidal agent against most gram-positive cocci that it is capable of eliminating them, or nearly so, from the respiratory tract. Under such circumstances, and for reasons which are as yet obscure, gram-negative flora may become pre-dominant and may, in themselves, and as in this case, perpetuate the infection. A number of cases of this nature are already on record (1) and more will be found

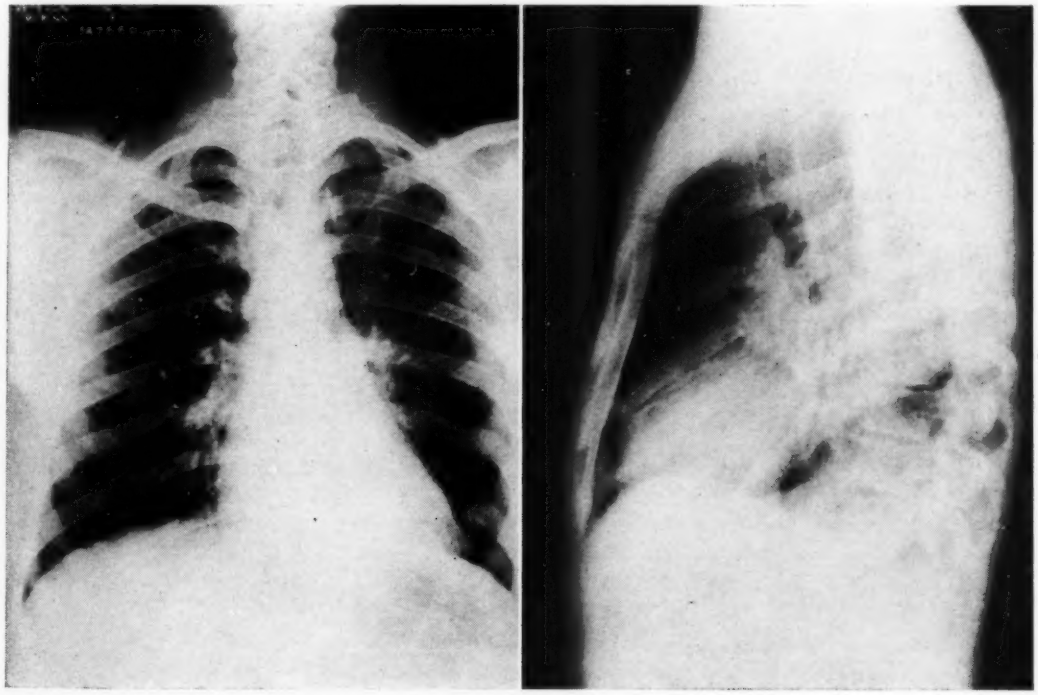


Figure 5. Case 3. Tularemic pneumonia. Note that in postero-anterior view lesion behind the cardiac shadow is not readily apparent. In lateral view, wedge-shape consolidation in left lower lobe can be seen.

Table 1. — Choice of Antibiotics Today (Nov. 1, 1949) in Infections by Microorganisms

	Penicillin	Streptomycin	Aureomycin	Chloramphenicol
1. Pneumococcus (Pneumonia, Mastoiditis, Meningitis)	A	C	B	C?
2. Streptococcus				
a. Group A beta hemolytic (most human infections)	A	C	B	0
b. alphahemolytic or viridans (SBE & chronic infections)	A	C	B	0
c. Group D, "entero-cocci" (strep. fecalis)	B	0	A	0
d. Anaerobic (post-partum, skin infections, pneumonia & empyema)	A	--	--	--
3. Staphylococcus — If severe infection such as bacteremia	A	0	B	0
	A+	0	B+	0
4. B. anthracis (Anthrax)	A (+S.D.)	0	--	--
5. Clostridia (Gas Gangrene, tetanus) (Surgery of most importance here)	A (+S.D.)	0	--	?
6. M. tuberculosis	0	A (PAS)	0	0
7. Meningococcus	A (+S.D.)	0	B? (1 case bacteremia)	--

Legend: A, first choice; B, second choice; C, third choice; D, fourth choice; 0, of no value; (--), value is unknown; (?), indicates choice is questionable because cases reported are too few; (+), indicates combined therapy necessary. S.D. = sulfadiazine. S.M. = sulfamerazine. PAS = para-aminosalicylic acid. S.A. = sulfacetimide.

when physicians learn to recognize the phenomenon. Only by repeated cultural studies and examinations of stained smears can this be detected and appropriate therapy instituted.

The following two cases illustrate the point that pneumonia may be caused by a great variety of infectious agents. There is often a tendency to oversimplify the etiologic varieties of pneumonia and to think of them in terms of either pneumococcal or "virus" types. When looked for, many other causes of pneumonia can be found.

CASE 2

A 61-year-old woman was admitted to Parkland Hospital, critically ill, on Nov. 11, 1948. All that could be obtained from relatives of the patient was the information that she had shaking chills 4 days before admission and since then had high fever, muscle aching, increasing respiratory distress and finally became semicomatose.

When admitted the patient had a temperature of 99 degrees, pulse rate of 120 per minute, and a respiratory rate of 80 per minute. She was an obese, cyanotic and severely dyspneic woman. Moist sticky rales were detected throughout both lung fields. The liver edge was palpated 2 finger-breaths below the costal margin. X-rays of the chest were interpreted as showing bilateral bronchopneumonia, although the possibility of pulmonary edema was also considered (Figure 3). The graphic temperature chart and pertinent laboratory data are recorded in Figure 4. It was at first considered that the patient was in congestive heart failure. However, rapid digitalization was accomplished without symptomatic benefit.

The temperature rose to 105 degrees on the 3rd hospital day; and at this time the skin and sclerae were visibly but slightly icteric. For a time, the possibility of acute pancreatitis was entertained. The temperature returned to normal, rose again by the 8th day to 104 degrees and then slowly fell to the normal level. During most of this time the patient was in a shock-like state. The outstanding therapeutic problem centered about the maintenance of water and electrolyte balance. Azotemia was present throughout the course of illness. The blood urea was 105 mgs% at the time of admission and rose on the 6th hospital day to 320 mgs%.

Severe oliguria, with 24 hour urine volumes of 100 to 200 cc. were present in the early stages of the illness; later as the azotemia subsided, a diuresis was recorded. The urine contained considerable quantities of protein, many red blood cells, and many granular and hyaline casts. On the 9th hospital day a non-descript generalized skin eruption was observed and on the same day, several tarry stools were passed.

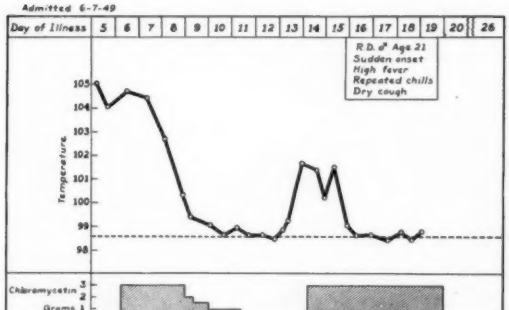


Figure 6. Case 3. Tularemic pneumonia. Response to chloromycetin, relapse when therapy discontinued, and response when re-administered.

Table 2. — Choice of Antibiotics Today (Nov. 1, 1949) in Infections by Microorganisms

	Penicillin	Streptomycin	Aureomycin	Chloramphenicol
8. Gonococcus	A (S.D.)	B	C	C
9. Pertussis	0	--	A (in mice)	? (A in vitro)
10. H. Influenzae				
Moderate	0	0	A	--
Severe (Meningitis)	0	B (+S.M. or S.D.)	A (+S.M. or S.D.)	--
11. Klebsiella pneumoniae (Friedlander's, B. mucosus capsulatus)	0	A (S.M.)	0	B?
12. Aerobacter aerogenes (B. lactis aerogenes)	0	B	A	A
13. E. Coli	0	B	A	A
14. E. typhosa	0	0	B	A
15. Salmonella Group (Paratyphoid)	0	0	C	A
16. Dysentery Bacilli	0	0	--	A??
17. B. tularense (Pasturella tularense)	0	B	A	A?
18. B. pestis (Pasturella pestis) (plague)	0	A	--	--
19. Brucella (Acute stage) (Undulant Fever)	0	0	A	A

Legend: A, first choice; B, second choice; C, third choice; D, fourth choice; 0, of no value; (--), value is unknown; (?), indicates choice is questionable because cases reported are too few; (+), indicates combined therapy necessary. S.D. = sulfadiazine. S.M. = sulfamerazine. PAS = para-aminosalicylic acid. S.A. = sulfacetimide.

Table 3. — Choice of Antibiotics Today (Nov. 1, 1949) in Infections by Microorganisms

	Penicillin	Streptomycin	Aureomycin	Chloramphenicol
20. Pseudomonas Aeruginosa (B. pyocyaneus)	0	A	0	A or B
21. Proteus vulgaris	0	B	0	A
22. Ducrey's bacillus (chancroid)	0	A	A	0
23. Rickettsiae (typhus, scrub typhus, Rocky Mt. spotted, Q. fever, Rickettsial pox)	0	0	A	A
24. Ornithosis (Psittacosis)	B	0	A	A?
25. Lymphogranuloma Venereum	B	0	A	A
26. Virus of atypical Pneumonia	0	0	A	A
27. Virus of Influenza	0	0	0	0
28. Common Cold	0	0	0	0
29. Rat Bite Fever (Haverhill Fever)				
a. Spirillum minus	B	0	A	--
b. Streptobacillus monoliformis	0	A	--	--
30. Treponema				
a. Syphilis	A	0	B	0 (in vitro & in animals)
b. Yaws	A	0	--	--
31. Leishmaniasis (Granuloma inguinale, Oriental sore)	0	A	A	A
32. E. histolytica	0	0	A	0
33. Trachoma	A (or S. D. orally or S. A. locally)	--	A (local)	--

Legend: A, first choice; B, second choice; C, third choice; D, fourth choice; 0, of no value; (--), value is unknown; (?), indicates choice is questionable because cases reported are too few; (+), indicates combined therapy necessary. S.D. = sulfadiazine. S.M. = sulfamerazine. P A S = para-aminosalicylic acid. S.A. = sulfacetimide.

The white blood cell count rose to 22,000 per cu.mm. with a left shift. Numerous other laboratory studies were performed and were either normal or contributed no pertient information.

It is believed by all who saw the patient that the tireless and judicious attention of the house staff, particularly with regard to the proper administration of fluids and electrolytes, was largely responsible for her eventual recovery. Penicillin and streptomycin were administered throughout most of the illness.

* Reported with the permission of the Clinical Director, Veterans' Hospital.

Table 4. — Choice of Antibiotics in Certain Clinical Conditions

	Penicillin	Streptomycin	Aureomycin	Chloramphenicol
1. Pneumonias (Remember that shifts in bacterial flora occur in debilitated patients)				
a. Pneumococcic	A (S.D.)	C	B	C?
b. Strep. beta hemolytic	A (S.D.)	C	B	0
c. Staphylococcic	A+	0	B+	0
d. Friedlander's (K. pneumoniae)	0	A (+S.M or S.D.)	0	B?
e. H. Influenzae	0	B (+S.M. S.D.)	A (+S.M. S.D.)	--
f. Tularemic	0	B	A	A?
g. Atypical Types				
(1) Virus	0	0	A	A
(2) Rickettsiae - Q fever	0	0	A	A
h. Tbc.	0	A (+PAS)	0	0

Legend: A, first choice; B, second choice; C, third choice; D, fourth choice; 0, of no value; (--), value is unknown; (?), indicates choice is questionable because cases reported are too few; (+), indicates combined therapy necessary. S.D. = sulfadiazine. S.M. = sulfamerazine. P A S = para-aminosalicylic acid. S.A. = sulfacetimide. S.T. = sulfathalidine.

COMMENT

The diagnosis of Weil's disease was established by the results of serum agglutination tests performed at the National Institute of Health, Bethesda, Maryland. For many days, the correct diagnosis in this case was unsuspected. In retrospect, however, the case is entirely typical of Weil's disease and could have been recognized on clinical grounds alone. The patient had an illness with sudden onset, chills, high fever, and muscle aching. The outstanding manifestations were those of acute nephritis, ie, oliguria, azotemia, and albuminuria, hematuria and cylinduria. In addition there was evidence of hepatomegaly, jaundice and a bleeding tendency. Diffuse bronchopneumonia is also a recognized feature of this disease. (2)

In Dallas, Weil's disease is probably not rare. Several cases have been recognized in local hospitals in the past few years, and undoubtedly other cases have not been diagnosed correctly. The most important aspect of treatment is the maintenance of normal fluid and electrolyte equilibrium, and in this regard the treatment is identical with that advocated currently for "lower nephron nephrosis". (3) Whether or not penicillin or streptomycin were of value in the survival of the patient is debatable. Recent investigations suggest that aureomycin might be preferable as a spirochetocidal agent. (4).

CASE 3

A 21-year-old white man was admitted to the Veterans' hospital at McKinney, Texas, on June 7, 1949, with the complaints of fever and cough.* The patient was a river fisherman, and in the course of his occupation often drank water from untested sources, and had numerous tick bites.

He became ill on June 2, 1949 with repeated chills, high fever, muscle and joint pains, abdominal pains, headaches, and a hacking unproductive cough.

At the time of admission he appeared acutely ill, lethargic, but rational, with temperature of 105 degrees. The important physical findings elicited were medium moist rales and dullness over the left lower portion of the chest, posteriorly. The initial white blood cell count was 3700 per cu.mm. with normal differential count. Urinalysis revealed normal findings. Blood cultures were subsequently reported as yielding no growth. Sputum cultures were not made.

The initial clinical impression was that of "virus" pneumonia. However, the abrupt onset with high fever and repeated chills (twice daily) are unusual in this disease. In addition, chest x-rays disclosed an area of lobar consolidation in the left lower lobe, rather than the usual type of feathery peribronchial infiltration (Figure 5). These x-rays also demonstrate the not-uncommon finding that lesions in the left lower lobe of the lung may be obscured by the superimposed cardiac shadow, and readily can be overlooked by the unwary. Lateral (or sometimes oblique) views may be necessary to demonstrate lesions in this location.

Typhoid fever was also considered as a likely diagnosis at the time of admission. It is well known that lobar or bronchopneumonia may be one of the prominent early manifestations of this disease. The occupational exposure and the leukopenia were consistent with typhoid fever, but the abrupt onset and absence of rose spots or splenomegaly on the fifth day of illness were at variance with the usual course of typhoid fever.

Finally, murine typhus was suspected and actually the history and findings were entirely compatible with this diagnosis, except for the absence of the charac-

Table 5. — Choice of Antibiotics in Certain Clinical Conditions

	Penicillin	Streptomycin	Aureomycin	Chloramphenicol
2. Sub-acute Bacterial Endocarditis				
a. Alpha hemoly. strep (viridans)	A	C?	B	0
b. Beta hemoly. strep	A (+S.D.)	C?	B	0
c. Streptococcus fecalis	B+	C?	A+	0
d. Staphylococcic	A+	0	B+	0
e. Micrococcus (Staph) Tetragenus 45	A+	B+	--	--
f. Gram-Negative Bacilli	0	A+	A+	A+
3. Urinary Tract infections (Remember surgery often more important)				
a. E. coli	0	B (S.A. or S.D.)	A	A
b. Aerobacter aerogenes (B. lactis aerogenes)	0	B (S.A. or S.D.)	A	A
c. Proteus vulgaris	0	B (S.A. or S.D.)	0	A
d. Pseudomonas aeruginosa (B. pyocyaneus)	0	A	0	A or B
e. Streptococcus fecalis	B	0	A	0
f. Staphylococcus	A	0	B	0

Legend: A, first choice; B, second choice; C, third choice; D, fourth choice; 0, of no value; (--), value is unknown; (?), indicates choice is questionable because cases reported are too few; (+), indicates combined therapy necessary. S.D. = sulfadiazine. S.M. = sulfamerazine. PAS = para-aminosalicylic acid. S.A. = sulfacetimide. S.T. = sulfathalidine.

teristic rash on the fifth day of illness.

Because all three of the diseases considered most probably respond favorably to treatment with chloromycetin, this drug was administered in adequate dosage. As can be seen in Figure 6, there was an apparently prompt response with a return of the temperature to normal in 48 hours. After several days of decreased dosage, chloromycetin was discontinued, following which the temperature rose again to 102 degrees. Upon the re-administration of chloromycetin there was again a prompt response to treatment and convalescense proceeded uneventfully.

None of the original diagnostic suggestions were confirmed by laboratory tests. Instead there was an unequivocal and diagnostic rise in the titer of serum agglutinins against **B. tulerense.**

COMMENT

Tularemia is a not uncommon disease in the Southwest. Infection may be contracted by the handling of infected wild animals or by tick bites. One-quarter or more of cases of tularemia exhibit pulmonary lesions (5). Local ulcers of the skin or eye and regional lymphadenopathy often are absent. This disease should be considered in the differential diagnosis of "virus" pneumonia, typhoid fever, typhus, etc.

Streptomycin is highly effective in the treatment of tularemia. Chloromycetin is believed to be effective as well, although clinical experience as yet is quite limited. On the basis of comparative laboratory studies aureomycin is thought to be the specific treatment of choice. In the small number of cases on which it has been used, the response to treatment has been satisfactory (6).

CONCLUSIONS

The objective in these case presentations has been to re-emphasize a few facts regarding pneumonia. Good treatment still requires knowledge of the specific causative agents. A large number of bacterial species, viruses, rickettsias, spirochetes, and fungi are capable of producing pneumonia in man. With the remarkable decline in the incidence of pneumococcal pneumonia in recent years, and the waning of "virus" pneumonia as an epidemic disease, a greater emphasis should be put on the proper recognition of other etiologic varieties of pneumonia. Potent chemotherapeutics sometimes complicate, rather than simplify, problems in the management of pneumonia, and are capable of suppressing the growth of one type of bacterial flora, permitting the overgrowth of another.

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Table 6. — Choice of Antibiotics in Certain Clinical Conditions

	Penicillin	Streptomycin	Aureomycin	Chloramphenicol
4. Preoperative & Postoperative in Intestinal Surgery	0	B	A?	A (S.T.)
5. Preoperative & Postoperative in Pulmonary Surgery	A	A	--	--
6. Ulcerative Colitis (Idiopathic)	0	0	0	?
7. Otitis Media	A	C (sulfa)	B	--
8. Poliomyelitis	0	0	0	--
9. Guillain-Barré's Syndrome	0	0	0	--
10. Hepatitis	0	0	0	--
11. Infectious Mononucleosis	0	0	0 Borate 0.5% sol. locally	--
12. Ocular Infections				
a. Staphylococcus, Pneumococcus, H. Influenzae, Morax-Axenfeld	Not desirable		A	--
b. Inclusion conjunctivitis, trachoma, other viruses	locally		A	--
c. Herpetic conjunctivitis			A?	--
d. Epidemic keratoconjunctivitis			A	--

Legend: A, first choice; B, second choice; C, third choice; D, fourth choice; 0, of no value; (--), value is unknown; (?), indicates choice is questionable because cases reported are too few; (+), indicates combined therapy necessary. S.D. = sulfadiazine. S.M. = sulfamerazine. PAS = para-aminosalicylic acid. S.A. = sulfacetimide. S.T. = sulfathalidine.

Undulant Fever

Six patients with active undulant fever (brucellosis), 5 proven by positive blood cultures, have been treated with Chloromycetin. The average duration of fever after the administration of this antibiotic was 2.4 days. The drug was administered over a period of 8.5 days and the mean total dosage per patient was 17:5 Gm.

The dosage recommended in treatment of this disease, on the basis of the above experience as well as in additional cases, is the initial administration of 60 mg. per Kg. of bodyweight and 0.25 Gm. every three hours thereafter for at least seven days of normal temperature. Chloromycetin would be expected to exert some beneficial effect in the chronic disease, but treatment will probably have to be prolonged. Therapeutic effectiveness in the chronic state may be difficult to evaluate.

ANTIBIOTICS AND THE TREATMENT OF VIRUS INFLUENZA

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and
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Considerable difference of opinion exists regarding the chemotherapeutic agent or antibiotic of choice in the treatment of virus influenza. With this in mind, a control study was undertaken to evaluate the effectiveness of the commonly used agents in the treatment of virus influenza. The material used in this study was 146 patients admitted for influenza out of an estimated 5000 cases in the surrounding area. All patients in this study had symptoms of influenza and sufficient temperature elevation to warrant hospitalization. The conditions for study were optimal as all patients were admitted at the onset of their disease, without receiving previous medication and were under constant supervision for the duration of this study. For treatment purposes, patients were divided into six groups, each of which received one of the following forms of therapy: aureomycin, penicillin, streptomycin, sulfadiazine, combined antibiotics and symptomatic therapy.

The offending virus in this epidemic was found to be "influenza A, Ft. Monmouth strain" as determined by the Fourth Army Area Medical Laboratory, Fort Sam Houston, Texas, utilizing the Hirst Test, (1) (2) which measures the level of neutralizing antibodies in the serum of patients with virus influenza.

METHOD OF STUDY

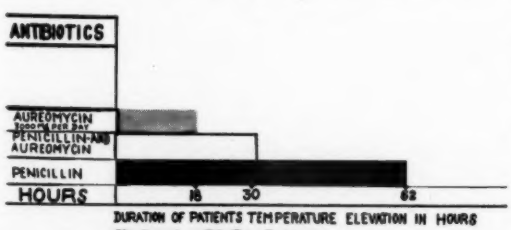
1. All patients were isolated in wards alloted to the infectious and contagious disease section. Medical and nursing personnel in attendance were thoroughly familiar with the care and management of contagious diseases.

2. Chest x-rays were made on all cases either on the day of or the day following admission and repeated as warranted by symptoms suggestive of pulmonary complications.

3. Complete history and physical examination was done at time of admission. Each patient was questioned carefully as to previous inoculation for influenza, especially as regards date and type of vaccine.

4. Routine laboratory procedures consisted of a complete blood count, including a Schilling differential and a urinanalysis. An erythrocyte sedimentation rate was done on 10% of the group; 5% received agglutination tests for infectious mononucleosis and brucellosis; 20% of the study group had the Hirst test for virus influenza; another 3% had blood cultures and liver function studies, including thymol turbidity, icterus index and cephalin cholesterol flocculation test.

5. Of the 146 patients, Group I, comprising 46%, were placed on 200,000 - 300,000 units of aqueous penicillin G, every 3-6 hours, varying with the severity of the initial clinical manifestations. Group II, comprising 22%, were placed on aureomycin, 3000 mg. per 24 hour period as the adult dose. For children syrup of aureomycin, 50 mg. per dram was given, dosage depending on weight of child. Group III, comprising 2%, received Streptomycin 1 - 1½ grams daily, by intramuscular injection. Group IV, comprising 5%, received only symptomatic treatment and no antibiotics. Group V, comprising 2%, received symptomatic therapy in addition to sulfadiazine, following an initial dose of 2 grams, 1 gram was given every four hours. Group VI, comprising 23%, were mainly women and children and treated in a separate wing of the infectious and contagious disease section, received aureomycin 1500 mg. and procaine penicillin in oil 300,000 - 600,000 units per 24 hour period. The dosage of aureomycin for children varied with their weight. Twenty percent of these cases initially received penicillin for less than twenty-four hours, then aureomycin was begun. The effect of the penicillin in these cases we feel was negligible. However, in as much as they did receive some penicillin they are included here. Their inclusion in Group II would have raised this group percentage to 27%.



DURATION OF PATIENTS TEMPERATURE ELEVATION IN HOURS FOLLOWING ANTIBIOTIC THERAPY

CLINICAL PICTURE

The clinical picture presented by this epidemic appears to be typical of those described elsewhere, (3) (4), in which the etiological agent was influenza virus, type "A". In the majority of cases the onset was abrupt, with the following sequence of symptoms: chilliness or chills, fever, vertigo, anorexia, headaches, lassitude, muscular pains and aches, non-productive cough, nausea and vomiting. Less frequent symptoms observed were: sneezing, nasal irritation with coryza, substernal discomfort, hoarseness and in one case, epistaxis. In this epidemic high temperature elevations were common and frequently elevated to 105 degress F. However, the calculated average was 102.2 degrees F.

PHYSICAL EXAMINATION

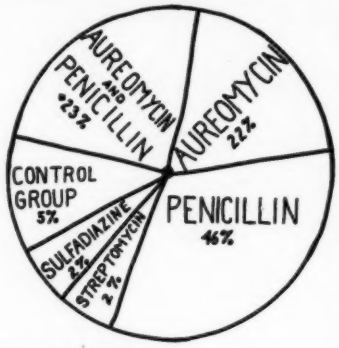
In this epidemic physical findings were few, consisting of moderately injected faucial pillars, soft palate, conjunctiva, nasal mucosa, and posterior pharyngeal walls.

A flushed face and enlarged tender cervical lymph glands were routinely observed. Many of these patients had a dry non-productive cough and some vague chest discomfort. However, on auscultation of the chest, there was no evidence suggestive of pulmonary involvement.

LABORATORY FINDINGS

All patients were submitted to routine laboratory procedures and the majority of these cases exhibited either a normal leukocyte count or a moderate leukopenia. Schilling differentials showed moderate lymphocytosis to be a common finding.

BREAK DOWN OF 146 CASES OF VIRUS INFLUENZA



*30% OF THESE CASES RECEIVED PENICILLIN FOR LESS THAN 24 HOURS WHICH INCREASES THE AUREOMYCIN GROUP BY 8%. (27% VIRTUALLY HAD AUREOMYCIN THERAPY ALONE.)

All blood cultures were sterile after 13 days. Agglutination test for infectious mononucleosis and brucellosis were negative. Liver function tests were within normal limits. Routine urinanalyses were done on all admissions, all of which were within normal limits except for a slight albuminuria which was a constant finding for the first day of the disease only.

All patients admitted to the hospital had a minimum of one roentgenogram of their chest made on day of or day following admission. In 30% of the cases, these x-rays were repeated to rule out the development of any pulmonary complication. All chest films were interpreted to be within normal limits except for one case admitted with rheumatic heart disease, who exhibited marked cardiac hypertrophy and pulmonary edema complicated by the influenza.

DISCUSSION

Prior to evaluating which of the antibiotics or chemo-therapeutic agents appearted to be of most value in the treatment of Influenza Type "A", all charts diagnosed as influenza were reviewed in regards to symptoms, physical and laboratory findings, prior to making the final diagnosis of virus influenza, and a tabulation made in regard to maximum temperature, type of therapy, duration of temperature, elevation, age, laboratory and roentgenographic findings and complications incurred. Following review of the maximum temperatures and their duration under each of the aforementioned forms of therapy, the following data was found:

Of those patients receiving large doses of aqueous penicillin G, the average maximum temperature elevation was 102.2 degrees F. The average duration of the temperature elevation under this form of therapy was sixty-two hours. Patients who were placed on standard dosages of aureomycin supplemented with procaine penicillin in oil twice daily had an average maximum temperature of 103 degrees F., and a duration of temperature elevation of 30.8 hours. The third, and most significant, group of patients were those who received large doses of oral aureomycin (3,000 mg. daily). The average maximum temperature for this group was 102.2 degrees F., and the average duration of the temperature of this group was 18 hours. The controlled group who received symptomatic therapy alone, and who unfortunately consisted of those with apparently the least severe cases of influenza, had a maximum temperature average of 101.2 degrees F., and an average duration of temperature of 56 hours. In the 2 smaller groups, which received streptomycin or sulfadiazine, we were unable to see that these drugs were of any value at all. In two of the cases, the disease progressed after 36 hours to such severity that we found it necessary to supplement the patient with aureomycin in order to control the temperature elevation.

CONCLUSION

From the material gathered in this epidemic of influenza A, aureomycin appears to be the antibiotic of choice in the therapy of this disease. Aureomycin given in large doses (3,000 mg. per 24 hour period) lowered the temperature elevation and ameliorated the symptoms of the disease in approximately 30% of the time that was required by penicillin G, and in approximately 50% of the time that was required by aureomycin given in small doses supplemented by 600,000 units of procaine penicillin in oil.

It is unfortunate that a larger group could not be studied on symptomatic therapy alone so that we would be better able to evaluate the usefulness of this drug as well as other antibiotics in preventing complications.

In this group studied there were only three patients with complications. There was one case of otitis media, one of acute mastoiditis and one with a staphylococcus lobar pneumonia. Each of these patients had been receiving penicillin prior to the development of the complication, but at the time the complications developed were on symptomatic therapy only.

Allergic manifestations to massive doses of aureomycin have been reported in the current medical literature. (5) (6) (7) In the groups receiving aureomycin, (Groups II and VI) comprising 45%, approximately 4% complained of nausea, pruritus and rectal excoriation and drug rash. The patients receiving aqueous penicillin G exhibited no allergic manifestations. Of those receiving procaine penicillin in oil, three developed allergic manifestations, manifested by severe itching and giant urticaria.

Further controlled study is needed in the use of aureomycin in virus influenza and other virus diseases before a definite conlusion can be reached as to its value in their treatment. However, from our study of aureomycin therapy in the treatment of type A, virus influenza, it appears to be a most effective drug.

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TRENDS IN HOSPITAL COSTS AND COMPENSATORY MEANS TO MEET THEM

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A speech delivered by Malcolm T. McEachern, M. D., F. A. C. S., Chicago, director of the American College of Surgeons, at the Surgeons' Regional Meeting in El Paso, 13 February 1950.

Thanks to good doctors, the cost of hospital care today is the lowest in the history of our nation. The percentage of the family income spent for hospital care in major surgery is less today than it was forty years ago, or even twenty-five years ago when I first came into hospital management. Forty years ago, for abdominal surgery the average stay in the hospital was fifty-four days; today for the same operation the average stay is between five and six days. Therefore, this patient is nine times better off from the standpoint of time spent in the hospital than he was 40 years ago. In addition to better professional care, the patient has improved comforts, better nursing and better service in every way, not mentioning the improved chances of going out alive and well. If hospitals should charge $25 per day, the American people would still get their hospital bill for less than they got it 40 years ago.

Forty years ago for delivery of a baby the average stay was fifteen days; today it is four days. This is due to the advance in medical science, for which we are grateful. If the patient pays $25 per day, which would be an equitable charge for maternity care, he still gets his hospital bill for less money than he did twenty years ago, even though the cost per day was less.

TRENDS IN COSTS

The trends in costs are still higher and higher per day for hospital care but less and less for operation per patient. Here again we pay tribute to our great medical profession, to the chemists and scientists for their contribution in making this possible. The trends are this way because of concentrated pharmaceutics that have been brought to bear in addition to the marvelous techniques developed by our surgeons. Let me explain why the concentrated drugs are so expensive (and this is something every person should know). Few people realize that it takes seven thousand pounds of fox glove leaves to make a gram of digitalis; that it takes eight thousand pounds of liver to make one gram of vitamin B-12, known as the red vitamin; that it takes the pancreas glands of seventeen cows to make one ounce of insulin; that it takes fifty-four tons of radium ore to make a gram of radium. These are a few examples of why these articles cost so much. Mr. Harold B. Clemenko had a splendid article in **Look Magazine** of January 17th concerning the plight of hospitals and in which he stated that for $1.30 worth of penicillin it costs $1.55 to administer it. Therefore, not only the cost of the concentrated pharmaceutics themselves but the administering of the drugs is often times two to three times as much as the inventory price. Occasionally a person will say, "I can get an aspirin for a nickel at a drug store", which is perhaps true, but in the drug store a diseased soda jerker hands him an aspirin and if the person buying the aspirin falls dead when he takes it, the soda jerker has no responsibility for what happened, whereas, in the hospital the aspirin is administered by a professional person who knows whether or not the aspirin would kill the patient if he takes it.

ADDED COST

One of the added costs of operating hospitals is that it is impossible to hire and fire employees in proportion to the increase and decrease in patient load. In other words, our load depends on the health barometer of the community. One week the hospital will be running over, with beds in the halls, sun parlors, etc., and the next week the hospital will have one-third of the beds empty. Yet, its personnel being professional people and hard to secure, must be kept on the payroll whether the hospital is full or not. Consequently, this adds to the increased cost of hospital care to the patient.

The American people get more for their money in a hospital than any other place on the American market. Their dollars go further and buy more in a hospital than any other place. For instance, if the patient is paying $12 per day for a private room in a hospital, he is only paying 50¢ per hour, because he gets twenty-four hours of care. For this 50¢ per hour, he is bathed in bed, fed in bed and gets toilet service in bed, and by actual count the average patient is served 37 times in twenty-four hours in a hospital by three 8-hour shifts of professional people and other employees. Ninety per cent of those who serve the patient have spent from three to ten years preparing themselves for this service. In comparison, what can we buy in the commercial world for 50¢ an hour? A housewife cannot get her dishes washed for 50¢ or get the lawn mowed. Other times a person will say, "I can get the same room in a hotel for $5.00", which is probably true, but that is all he gets in a hotel. If in a hotel in your $5.00 room they should wait on you 37 times, you would have paid out, in addition to the $5.00, $9.25 for tips making $14.25 paid out, and then, in the hotel if they should bathe you in bed, feed you in bed, give you toilet service in bed, change the linens from 6 to 10 times, catheterize you in bed, you would have to float a bond issue to get out.

The public should remember the most sacred thing in life is life itself. No man I know of works as hard or disciplines himself as much as a practicing physician. I have served and worked with the medical profession for over twenty-five years, and they are the greatest men on earth. The average doctor charges less per hour for calling on a patient than a master plumber. It costs nine times as much to have your house painted by a union painter, if painted around the clock, than it does to stay in the finest room in the finest hospital in our city. The trouble is, people do not know how to judge values. A man will give $25,000 to hire a criminal lawyer to defend him from the electric chair, where he should probably go, and yet a doctor can charge him $1,000 for saving his life and he will tell everybody in the country about it and refuse to pay the bill.

RECENT STUDY

A study which we made recently of representative items used by the hospital showed that from 1940 to 1949 food had increased over 300% on some items.

To be exact the range was from 87% on the food item with the smallest increase to 306% on the items with the greatest increase. Drugs had increased all the way from 10% to 170%. Practically the same was true of dressings, linens, laundry and hospital supplies. Labor had increased all the way from 105% to 243%, and no consideration was given in this computation to shorter hours worked. Since this study was made, there have been further increases in labor costs.

While in recent months there have been slight decreases in some items, such as food, for instance, our prognostigators of economic trends are practically unanimous in their predictions that in order to produce the taxes to meet what appears to be a permanent national budget of astronomical proportions it is going to be necessary to maintain high prices, high wages and a high level of economic activity. They predict that further money tinkering may be resorted to by the Congress and the Administration in order to accomplish this. We may assume then that the high prices and high wage costs may be with us for several years to come. Necessity is the mother of invention. Such means as have been placed in effect in the past to control and offset these rising costs must be continued and new means developed.

We have spared no effort or money to secure top caliber people to head the different departments of our hospital. That this has paid off in dividends is evidenced by a study which was recently made by us, comparing our costs with the cost of operating hospitals of comparable size and located in the South Central part of the United States. This study showed that while our administrative costs were higher than the average of other hospitals in this area, our over-all costs were lower. Cheap management is no economy.

DEPARTMENTS MEET

Each Monday morning we have a meeting of all these department heads of the Hospital. All problems pertaining to service to patients, safety, expense control, public information, etc., are discussed in detail and policies established. A stenographer takes notes of all discussion and action taken at these meetings. These minutes are read at the succeeding meeting to make sure that the procedures decided upon are duly placed into effect.

We recently placed into effect an air-tight purchase order system and hired a purchasing agent of high ability and with previous experience in this line. This purchase order system provides that all requisitions for purchases must be signed by the head of the originating department and approved by the administrator before passing to the purchasing department for securing quotations, bids, and issuance of purchase order. Requisitions for items issued from stock must be signed by the department head before presentation to the storekeeper. We have not overlooked competitive bids and any institutional discounts to which we are entitled. Neither have we overlooked the fact that food and drugs comprise a large portion of the cost of supplies. Since our hospital is a non-profit community institution, we have made application to share in the surplus food distributed by the U. S. Department of Agriculture. Also, we are considering at the present time the possibility of establishing, in collaboration with other hospitals in the area, a central purchasing agency. If prices continue to advance, we may be forced to take definite action in this respect.

Some time ago we made a study of discounts on billing allowed to various organizations and individuals. A number of these were reduced and some discontinued entirely. We have adopted the use of plastic dishes throughout the hospital and this has reduced replacement of dishes to practically nil.

ACCOUNTING DEPARTMENT

In the accounting department, too, we have adopted short-cuts and machine operations. While these have not reduced expenses, they have had the effect of avoiding additional expenses as the hospital enlarges or have released effort which has been employed to give management additional statistical and accounting information for its use in controlling expenses. As examples; we now use composite rates of depreciation for the various classifications of property and this depreciation computation is made annually instead of monthly and on each item of equipment. Our reports are presented in even dollars only. Some are presented in even $100. This saves time in typing or makes possible more information in the same report. Also, we have presented certain reports in graph form only. This eliminates typing entirely and gives a better picture at a glance of comparisons and trends. In the case of some reports the figures are copied on the duplicating process in pencil and are duplicated without typing.

The County charity load at our Hospital is almost as large as all other hospitals in the County combined. The County pays only a fraction of the cost of servicing these patients. We have taken definite steps to secure at least the cost of these cases. We have been informed that in cases where legal action has been taken against the County, reimbursement for full billing has been secured, however, we have not taken this action to date but rather are attempting to work the matter out in an amicable manner with all concerned.

The Finance Committee of the Board of Trustees require that we operate under a budget. Prior to the beginning of each year we are required to submit to this Committee for its approval our operating cash and construction budgets. This has been a very beneficial step in that it enables us to plan considerably in advance to meet certain situations and get full utilization of our cash resources.

LABOR COSTLY

We have not overlooked the fact that labor usually comprises from 55% to 60% of the total operating cost of hospitals. The system of controlling payrolls which we have partially installed and are in process of completing, provides approval of personnel manager, department head and administrator for new employment. A medical examination is also a prerequisite. This system provides that each regular position is numbered. New authorizations are not required in the case of these regular employees unless change in rate of pay of position occurs. In the case of temporary employees new authorizations must be turned in every 15 days. It often occurs in the case of a temporary employee that he or she becomes a permanent employee merely because there is no follow-up on the part of the management. This system will make it necessary to review these cases at frequent intervals to make sure that a new position has not been created without full knowledge and consent of the management.

Some commercial concerns have been able to offset rising costs by mechanization, however, hospitals cannot employ this means to an appreciable extent because most patients require the personal services of highly trained professional people. Our new building and modernization plans do provide a number of mechanical improvements which will save a lot of time and steps, such as, intercommunication system between patients rooms and the nurses' stations, pneumatic tubes for dispatching charts, charge tickets, etc., to and from the floors.

The plans for construction now in progress provide for a pay cafeteria and we believe that this will reduce considerably the cost of food. We also plan a central admitting system and this provides for the heading of every form produced in the hospital at one typing at the time the patient is admitted.

Castration and Breast Cancer

Castration as an adjunct to the treatment of breast cancer was suggested independently by Schinzinger in 1889 and by Sir George Beatson in 1886. The results of such treatments have been reexamined recently. According to Adair,[11] transient beneficial response may be expected in 15 to 30 per cent of castrated patients who have advanced recurrent or metastatic disease, and little or no response is to be expected in the primary tumor or in lymph gland metastases. The patients who improve are almost entirely in the premenopausal group. X-ray castration may produce good results. In some in whom it fails the failure is suspected to be due to incomplete castration effects of the x-ray. A good result is manifested by relief of pain, increase in appetite and weight, regression of bone metastases, and occasionally pulmonary metastases. Unfortunately, beneficial response is transient.

"The Use of Sex Hormones in Cancer" — E. Perry McCullagh, M. D., Cleveland Clinic Quarterly, January, 1950.

Congenital Polycystic Disease of the Kidney

". . . the typical patient with congenital polycystic disease of the kidneys will have a family history of renal disease and may expect symptoms to appear during the fourth or fifth decade of life. . . . A history of recurrent infections of the urinary tract and possibly renal colic may be elicited. On examination one or both kidneys may be palpated as irregular, hard masses. The blood pressure will probably be found to be moderately elevated with minimal to moderate hypertensive changes in the ocular fundi. Laboratory examinations may reveal albuminuria and pyuria of varying degrees. The intravenous pyelogram will show elongated calices with some blunting and irregularity of outline. Such a patient ordinarily will have a life expectancy of approximately 10 years after the onset of symptoms and has a fair chance for a normal life span. A poor prognosis is indicated by increase in the size of the kidneys, increase in severity of symptoms, progression in associated hypertensive vascular disease or advancing impairment of renal function."—Rall, J.E., and Odel, H.M., *Am.J.M.Sc.* 218:399, 1949.

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Attened Conventions

We have leaned over backwards in a liberal policy of sending our department heads to national, regional and state conventions. I don't believe that there has been a single case where the department head did not bring back information for the hospital of far more value than the cost of the trip. I wager that by the time this convention is over each one in attendance will carry back to your hospital information that will more than pay for your time and expenses.

As a general rule, hospital employees live like sharecroppers. They do not enjoy pensions and other benefits enjoyed by persons in industrial employment. This is true because the charity load of the hospital must come out of the sick man who does pay his bill and out of sub-standard wages and benefits of hospital employees. We must be on the alert to increase these benefits to employees just as fast as conditions will permit.

A large portion of the financial troubles of voluntary hospitals is due to the fact that the sick and those who care for the sick do not have grandeur. Men and women of wealth have put their money into such things as football stadiums, race tracks, fountains and statues. Many wealthy oil men think nothing of giving $30,000 for a white-faced bull, but ask them for $100 for a red-headed child and they have such a hard luck story that before they are through with you, you are about to pass the hat for them. Our hospitals in the South are not endowed; they are in debt. The only way we can get money to operate is to twist it out of the backs of sick people, therefore, we have a moral duty to make sure that we as hospital employees make full utilization of our talents and resources and thereby give to the people we serve the maximum service at the least possible cost.

NU - 445

Urinary excretion studies revealed that NU-445 is eliminated promptly.

It is concluded that the new drug is a valuable adjuvant in the treatment of urinary tract infections caused by B. pyocyaneus and E. coli.

JOSEPH A. LAZARUS AND LEWIS H. SCHWARZ, B.S.,
875 Park Ave., New York, N. Y.

REORGANIZATION PLAN NO. 27

(Continued from Page 216)

Hoover Report has issued a statement in opposition to Plan No. 27.

Again, American medicine must register its disapproval of the welfare state trend exhibited in this bill. Again, we must seek the approval of the Hoover Commission recommendation for an independent agency to co-ordinate and administer all federal health services.

You are urged to write, and have your lay friends write, to your Senators and Congressmen expressing opposition to Reorganization Plan No. 27. Action is imperative. The plan goes into effect July 31, 1950, unless vetoed before that time. You may rest assured that the sales department of your government is working diligently for the acceptance of this plan. Let's again prove that we don't like the price.

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